

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 2, 2016

████████████████████
████████████████
████████████████████

IBR Case Number:	CB16-0000032	Date of Injury:	02/19/1998
Claim Number:	██████████	Application Received:	01/07/2016
Claims Administrator:	██████████		
Date(s) of service:	10/21/2015 – 10/24/2015		
Provider Name:	████████████████████████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	DRG 470		

Dear ██████████:

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$195.00 for the review cost and \$20,079.07 in additional reimbursement for a total of \$20,274.07. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$20,274.07 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: ██████████
████████████████████████████████████████

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Official Medical Fee Schedule
- Negotiated contracted rates: Contract Agreement

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE:** Provider is seeking reimbursement of DRG 470 for dates of service 10/21/2015 – 10/24/2015.
- Claims Administrator denied reimbursement with indication “We cannot review this service without necessary documentation. The support data for the claim is missing”
- Provider submitted ICD 10 PCS codes for dates of service 10/21/2015 – 10/24/2015.
- The 2016 ICD-10 Procedure Coding System (ICD-10-PCS) is the new procedure coding system, ICD-10-PCS, that is a replacement for ICD-9-CM, Volume 3. These 2016 ICD-10-PCS codes are to be used for discharges occurring from October 1, 2015 through September 30, 2016.
- DRG 470: MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC.
- Notice of Authorization dated August 18, 2015 indicates “Authorized” for “Right total knee replacement at hospital” with certification to expire on 11/30/2015.
- § 5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed

pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.

- Opportunity for Claims Administrator to Dispute letter was sent on 1/8/2016. A response from Claims Administrator was not received for this review.
- Based on aforementioned documentation, reimbursement of DRG 470 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of DRG 470

Date of Service: 10/21/2015 – 10/24/2015					
Inpatient Services					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
DRG 470	\$45,279.18	\$0.00	\$20,079.07	\$20,079.07	DISPUTED SERVICE: Allow reimbursement \$20,079.07

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